ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
(Under Provision of A.A.C. R9-6-401, et seq)
(APPLICATION – REVISED 6/22/06)

The information contained in this document is confidential under the provisions of A.A.C. R9-1-311, et seq.

PAGE 1 - TO BE COMPLETED BY APPLICANT

APPLICANT INFORMATION: **RETURN TO: (SEE PAGE 2)**

I am a resident of Arizona _____YES _____NO (*YOU MUST SUBMIT PROOF OF RESIDENCY AS SPECIFIED IN THE "APPROVED RESIDENCY DOCUMENTATION" LIST)*

Name:_____Birthdate:_____/_____/_____
First Middle Last Month Day Year

Residential Address: _____ City:_____ State:_____ Zip Code:_____

Mailing Address:_____ City:_____ State:_____ Zip Code:_____

RACE: [ ] White [ ] Black or African-American [ ] Asian [ ] Native Hawaiian/Pacific Islander [ ] Am. Indian Or Alaskan Native [ ] Other ETHNICITY: Hispanic or Latino/a [ ] NO [ ] YES

Primary Phone Number: (_____)_____ Secondary Phone Number: (_____)_____ Gender: _____

My current total annual family income from all sources is $_____ (include income for all adult family members), and the number of persons in my family, including myself, is _____. (The definition of family is two or more persons living together who are related by birth, marriage or adoption.) Please list names and ages of family members: 1._____ 2._____ 3._____ 4._____ 5._____ 6._____

CURRENT EMPLOYMENT STATUS: [ ] Private/Public Employer [ ] Self-Employed [ ] Unemployed

[ ] Other (specify) _____

Are you eligible for Medicare? _____NO _____YES When will you become Medicare eligible? _____

I am currently receiving benefits from the Arizona Health Care Cost Containment System (AHCCCS). _____NO _____YES

I have an AHCCCS eligibility appointment scheduled for (date) _____.

Did you ever serve on active duty in the Air Force, Army, Coast Guard, Marines, Navy, or as a National Guardsman or Reservist?

_____ NO _____ YES

I currently have health insurance that would pay for all or part of the cost of medications provided by this program. _____NO

_____YES (IF YES, _____PART OR _____ALL)

I understand that I must provide proof to ADHS that I am not eligible to receive benefits from AHCCCS within 30 days of the date of this application (if proof is not submitted at the time of this application) in order to receive additional medications (if I qualify for the program and funding is available to the program). I grant permission to ADHS to use my name in discussing my application with the AHCCCS office for purposes of determining AHCCCS eligibility; Medicare and the Social Security Administration, for the purpose of determining eligibility for low income subsidy; the vendor pharmacy, to assist with drug distribution; primary care provider; or, any other entity required to establish or assist with drug distribution. I also understand that I must provide proof of my income (and proof of income for all other family members, if applicable) to ADHS with this application.

I, _____, certify that to the best of my knowledge and belief, all statements made herein regarding personal and other non-medical information are true and accurate. I certify that I am or my child or ward is not covered by any health insurance plan that would provide the support for which I am or my child or ward is applying. I understand that eligibility does not guarantee that the Arizona Department of Health Services will be able to provide support and that such support, if begun, may be terminated without notice.

_____ _____
Applicant's Signature Date

(PAGE 2 MUST BE COMPLETED BY HEALTH CARE PROVIDER)

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PAGE 2 - TO BE COMPLETED BY HEALTH CARE PROVIDER

APPLICANT'S NAME _____

HEALTH CARE PROVIDER'S NAME _____
MEDICAL LICENSE NUMBER: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) - _____ - _____ FAX NUMBER: (_____) - _____ - _____

This applicant has been diagnosed as having HIV infection.

	RESULTS	DATE OF TEST	LABORATORY NAME & ADDRESS
WESTERN BLOT:	_____	_____	_____
CD_4 CELL COUNT	_____	_____	_____
VIRAL LOAD TESTING (If available)	_____	_____	_____

*MEDICATION(S) BEING PRESCRIBED FROM THE MOST CURRENT ADAP FORMULARY [ATTACH/ENCLOSE ORIGINAL PRESCRIPTION(S)]:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I certify that to the best of my knowledge and belief all medical information presented by me in this application is true and accurate.

_____ _____

Health Care Provider's Signature Date

RETURN TO: OFFICE OF HIV/AIDS
AIDS Drug Assistance Program (ADAP)
150 North 18th Avenue, Suite 110
Phoenix, AZ 85007-3233
(602) 364-3594 or 3595/(800) 334-1540
Fax: (602) 364-3263